Background Check Appeal Request – IRIS

Instructions: IRIS participants may request a background check appeal on behalf of an applicant/worker with criminal convictions that determine the applicant/worker cannot be reimbursed for IRIS services by Medicaid as a participant-hired worker. The participant must complete all required sections of this form to request an appeal through the Department of Health Services.

The completed and signed form must be sent within 60 days after the date indicated on the participant's IRIS Background Check Results Notification Letter to:

Wisconsin Department of Health Services
IRIS Background Check Appeals
201 E. Washington Ave., Room B300
Madison, WI 53703

Completion and submission of this form is voluntary. Personally identifiable information on this form is collected to verify that the request is complete and will be used for this purpose. IRIS program representatives will keep identities confidential.

If the required sections of this form are not complete or the form is not mailed to the address provided above within 60 days after the date indicated on the participant's IRIS Background Check Results Notification Letter, the request for an appeal will be denied.

Section I: Participant information (required)

1. Participant's name (Last, First, MI): _____

2. Participant's MCI number: _____

Section II: Applicant/Worker information (required)

1. Applicant's/Worker's name (Last, First, MI): _____

2. Applicant's/Worker's date of birth: _____

Section III: Job duties (required)

The appeal review includes evaluating whether the applicant's/worker's conviction(s) is substantially related to the IRIS services that the participant-hired worker would provide. Please list the type and quantity of services the applicant/worker would provide to you if determined to be qualified to be reimbursed for IRIS services by Medicaid.

Section IV: Summary of convictions (required)

Please list the conviction(s) being appealed including the specific name(s) of the conviction(s), statute number(s) of the conviction(s), and date(s) of the conviction(s).

Section V: Summary of rehabilitation (required)

Please describe in detail your assessment as to how this applicant/worker has been rehabilitated for the purpose of being qualified to provide you with IRIS services that are reimbursed by Medicaid. Examples of rehabilitation may include, but are not limited to, public or community service, volunteer work, recognition by other public or private authorities for accomplishments or efforts, attempts at restitution, and/or successful participation in or completion of recommended rehabilitation, treatment, or programs.

Section VI: Summary of work environment (required)

Please describe in detail your assessment of your safety with regard to the conviction(s) being appealed including the type/amount of supervision that would be provided for the applicant/worker if determined to be qualified to provide you with IRIS services that are reimbursed by Medicaid.

Section VII: Submission of personal references and statements (optional)

Personal references and statements from persons and agencies familiar with the applicant/worker (i.e., therapists, counselors, other professionals, employers, etc.) may be included with the appeal request submission. Submission of personal references and statements on behalf of the applicant/worker is optional.

Section VIII: Signature (required)

My signature indicates that the information that I have provided is true and accurate and was provided of my own free will. I acknowledge that I understand that I am not obligated to engage in the appeal process if I would prefer to hire a different participant-hired worker or agency to provide my IRIS services.

Signature — IRIS participant: _____ Date signed: _____

Signature — Legal decision maker: _____ Date signed: _____